

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician and in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01128

CERTIFICATE OF DEATH

02317

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY St. Mary's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Abell		c. LENGTH OF STAY IN TB 34 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Abell	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Catherine Anderson Beitzell			4. DATE OF DEATH Month Day Year January 31, 1961		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 26, 1876	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Washington D.C. U.S.A.	
13. FATHER'S NAME Charles Frederick Husemann			14. MOTHER'S MAIDEN NAME ? ? ? Lewis		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs Mary Frances Owens Abell, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation DUE TO Conditions, if any, which gave rise to immediate cause (b) Chronic myocarditis, (c) Recurrent coronary thrombosis DUE TO cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 48 hrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.					
22a. SIGNATURE J. Roy Guyther			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type or print) J. Roy Guyther M. D.			22d. ADDRESS Mechanicsville, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/3/62	23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery	23d. LOCATION (City, town or county) (State) Washington, D. C.		
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley			25a. REC'D BY REGISTRAR Leonardtwn, Maryland		
			25b. REGISTRAR'S SIGNATURE DATE FEB 7 '62		

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01129

01119

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain in the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ST. MARY'S b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown c. LENGTH OF STAY in lb 1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PENNIES BAR				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE MARYLAND b. COUNTY St. Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLEMENTS d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ritchie Middle JAMES Last DOWNES				4. DATE OF DEATH Month 1 Day 28 Year 1962			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 27, 1923	
9. AGE (In years last birthday) 38 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Downs				14. MOTHER'S MAIDEN NAME Agnes M. Hall			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes W W 11		16. SOCIAL SECURITY NO. 218-14-3533		17. INFORMANT Lillian G. Downs RFD 2 Leonardtown, Maryland.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple shot gun wounds DUE TO (b) 781X Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) 781X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Was standing at bar in Pennies when fired upon point blank with 12 gauge shot gun						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Was standing at bar in Pennies when fired upon point blank with 12 gauge shot gun	
20c. TIME OF INJURY Month, Day, Year 7:30 p.m. 1-28, 1962		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bar		20f. (City or town) (County) (State) Leonardtown St. Mary's Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE RUSSELL S. FISHER, M.D.				DATE SIGNED 1-29-62			
EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.				DEPUTY MEDICAL EXAMINER 1-29-62			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/31/62		22c. NAME OF CEMETERY OR CREMATORY Sacred Heart		22d. LOCATION (City, town, or country) (State) Bushwood, Maryland	
23. FUNERAL DIRECTOR W. Clarke Mattingley Leonardtown, Maryland				24e. REC'D BY REGISTRAR DATE JAN 31 '62			
				24b. REGISTRAR'S SIGNATURE Clara S. Howard			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. To funeral director: To burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01120

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		c. LENGTH OF STAY IN 1b 18 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Mary's Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Lucy Last Drury		4. DATE OF DEATH Month January Day 14 Year 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 14, 1876
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William T. Bailey		14. MOTHER'S MAIDEN NAME Mary Elizabeth Swann	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. William A. Drury. 1323 E. Capitol St., S.E.	
17. INFORMANT William A. Drury. 1323 E. Capitol St., S.E.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Burns (2nd & 3rd. Degree- 90%) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) House coat caught fire while working around kitchen stove.		INTERVAL BETWEEN ONSET AND DEATH 20 hrs.	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 9:00 a.m. Jan. 13 19 62		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Clements, St. Mary's, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE William D. Boyd M. D.		DATE SIGNED 1/14/62	
EXAMINER'S NAME (Type) William D. Boyd M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/17/'62	
22c. NAME OF CEMETERY OR CREMATORY St. Josephs Cemetery		22d. LOCATION (City, town, or county) (State) Morganza, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland		24a. REC'D BY REGISTRAR JAN 19 '62	
ADDRESS		24b. REGISTRAR'S SIGNATURE William D. Boyd	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and within 72 hours after death.

VR A15 (4)
ISM 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01131									
01121									
1. PLACE OF DEATH a. COUNTY St. Mary's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Colton Point c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Colton Point d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First John Middle Samuel Last Dyson					4. DATE OF DEATH Month January Day 18 Year 1962				
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 26, 1884		9. AGE (In years last birthday) 77 IF UNDER 1 YEAR: Months 77 Days 77 IF UNDER 24 HRS.: Hours 77 Min. 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. Young					14. MOTHER'S MAIDEN NAME Nellie Mack				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)				16. SOCIAL SECURITY NO. none		17. INFORMANT Stelle Dyson Address Colton Point, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral hemorrhage Conditions, if any, which gave rise to immediate cause (b) Generalized atherosclerosis (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). INTERVAL BETWEEN ONSET AND DEATH									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. 19 p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from Dec 15, 1962 to 18 Jan 1962 that (I) (we) last saw the deceased alive on 15 Jan 1962 , and that death occurred at 6 AM , from the causes and on the date stated above.									
22a. SIGNATURE Joseph E. Gillo M.D.					22b. DATE SIGNED 1/19/62				
22c. PHYSICIAN'S NAME (Type) Joseph E. Gillo M. D.					22d. ADDRESS Leonardtown, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/19/62		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery		23d. LOCATION (City, town or county) (State) Bushwood, Maryland			
24 FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley ADDRESS Leonardtown, Maryland					25a. REC'D BY REGISTRAR JAN 24 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

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U.S. AIR FORCE, 1955

Discussion

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John H. Young

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Submitted January 6, 1987

CONCLUSIONS

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Clarke, George, 1891-1970

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div> <div> <div>18 Film 306</div> <div>20-62</div> </div> <div> <div>Item 14 Film G305</div> <div>1/16/62 ink</div> </div> </div> <div> <div>18 Film 306</div> <div>20-62</div> </div> <div> <div>Item 14 Film G305</div> <div>1/16/62 ink</div> </div>											
<div> <div> <div>1. PLACE OF DEATH</div> <div>a. COUNTY</div> </div> <div> <div>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</div> <div>a. STATE</div> </div> </div>											
<div> <div> <div>St. Mary's</div> <div>MARYLAND</div> </div> <div> <div>Pennsylvania</div> <div>Washington</div> </div> </div>											
<div> <div> <div>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>c. LENGTH OF STAY IN 1b</div> </div> <div> <div>USNAS, Patuxent River</div> <div>1 yr 2 mon.</div> </div> </div>											
<div> <div> <div>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)</div> <div>d. STREET ADDRESS</div> </div> <div> <div>Station Hospital, USNAS, Patuxent River, Md.</div> <div>Donora</div> </div> </div>											
<div> <div> <div>3. NAME OF DECEASED (Type or print)</div> <div>4. DATE OF DEATH</div> </div> <div> <div>Vance</div> <div>FRAZIER</div> </div> </div>											
<div> <div> <div>5. SEX</div> <div>6. COLOR OR RACE</div> </div> <div> <div>Male</div> <div>Negroid</div> </div> </div>											
<div> <div> <div>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/></div> <div>8. DATE OF BIRTH</div> </div> <div> <div>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div> <div>12-27-40</div> </div> </div>											
<div> <div> <div>9. AGE (In years last birthday)</div> <div>IF UNDER 1 YEAR</div> <div>IF UNDER 24 HRS.</div> </div> <div> <div>21 yrs.</div> <div>Months Days</div> <div>Hours Min.</div> </div> </div>											
<div> <div> <div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>10b. KIND OF BUSINESS OR INDUSTRY</div> </div> <div> <div>Mariner</div> <div>U.S. Navy</div> </div> </div>											
<div> <div> <div>11. BIRTHPLACE (State or foreign country)</div> <div>12. CITIZEN OF WHAT COUNTRY?</div> </div> <div> <div>North Charlero, Penna.</div> <div>USA</div> </div> </div>											
<div> <div> <div>13. FATHER'S NAME</div> <div>14. MOTHER'S MAIDEN NAME</div> </div> <div> <div>Vincent FRAZIER</div> <div>unknown</div> </div> </div>											
<div> <div> <div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</div> <div>16. SOCIAL SECURITY NO.</div> </div> <div> <div>Yes</div> <div>4 Nov. 56</div> </div> </div>											
<div> <div> <div>17. INFORMANT</div> <div>Address</div> </div> <div> <div>Service Record, Patuxent River, Md.</div> <div>Station,</div> </div> </div>											
<div> <div> <div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div>19. WAS AUTOPSY PERFORMED?</div> </div> <div> <div> <div>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)</div> <div>ASPHYXIA</div> </div> <div> <div> <div>825x</div> <div>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</div> </div> <div> <div>Traumatic transection of hypopharynx at hyoid bone</div> </div> </div> </div> </div>											
<div> <div> <div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)</div> <div>19. WAS AUTOPSY PERFORMED?</div> </div> <div> <div> <div>15 min. estimated</div> <div>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div> </div> </div> </div>											
<div> <div> <div>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.</div> <div>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</div> </div> <div> <div>Automobile accident on board the Naval Air Station,</div> <div>Patuxent River, Md.</div> </div> </div>											
<div> <div> <div>20c. TIME OF INJURY</div> <div>20d. INJURY OCCURRED</div> </div> <div> <div>0005 x Jan. 1 1962</div> <div>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/></div> </div> </div>											
<div> <div> <div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div> <div>20f. (City or town)</div> </div> <div> <div>USNAS, Patuxent River, Md.</div> <div>Patuxent River, Maryland</div> </div> </div>											
<div> <div> <div>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:</div> <div>22. DATE THEREOF</div> </div> <div> <div>Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></div> <div>22b. DATE THEREOF</div> </div> </div>											
<div> <div> <div>ACTUAL SIGNATURE</div> <div>EXAMINER'S NAME (Type)</div> </div> <div> <div>H. E. BERGE, LT MC USN</div> <div>William D. BOYD MC</div> </div> </div>											
<div> <div> <div>22a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>22c. NAME OF CEMETERY OR CREMATORY</div> </div> <div> <div>Transportation 1/3/62</div> <div>Donora, Pennsylvania</div> </div> </div>											
<div> <div> <div>23. FUNERAL DIRECTOR</div> <div>24b. REGISTRAR'S SIGNATURE</div> </div> <div> <div>P. B. Robinson</div> <div>Charles S. Krasa</div> </div> </div>											
<div> <div> <div>24a. REC'D BY REGISTRAR</div> <div>24b. REGISTRAR'S SIGNATURE</div> </div> <div> <div>DATE 8 '62</div> <div>Charles S. Krasa</div> </div> </div>											

01132

St. Louis

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St. Louis, Missouri

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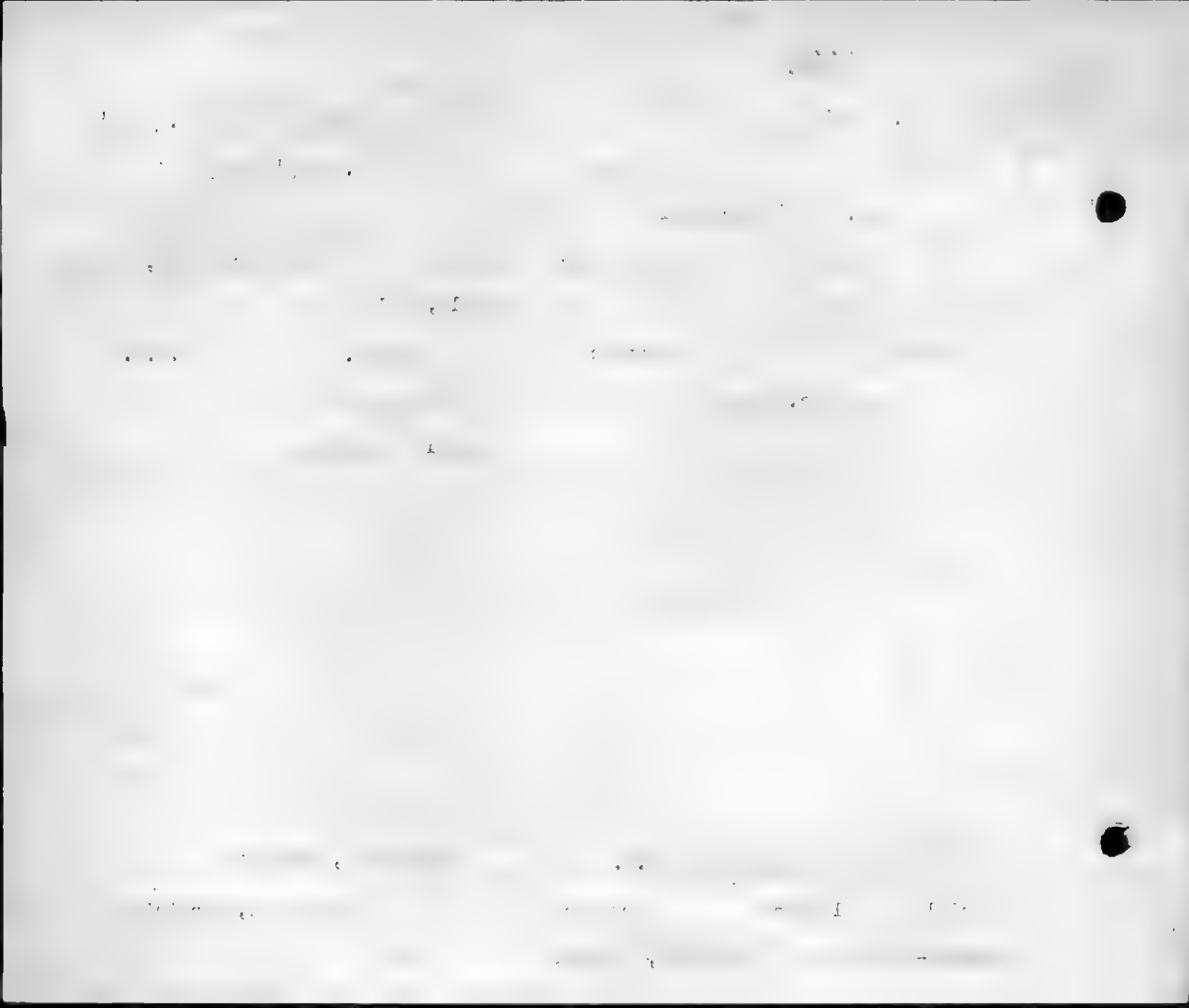
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
01133															
01123															
1. PLACE OF DEATH a. COUNTY St. Mary's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown, c. LENGTH OF STAY IN lb 48 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Mary's Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural St. Mary's City d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Eva Chamberlain Garner First Middle Last				4. DATE OF DEATH January 21, 1962 Month Day Year				5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>							
8. DATE OF BIRTH June 13, 1876				9. AGE (In years last birthday) 85 yrs				10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours M.n.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Domestic				11. BIRTHPLACE (County & State, or foreign country) Mass.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James De. Chamberlain				14. MOTHER'S MAIDEN NAME Helen Holmes											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>				16. SOCIAL SECURITY NO. <input type="checkbox"/>				17. INFORMANT Hospital Records Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 4 4 4 X DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertension + Smellity (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/>												INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1/20 , 19 62 , to 1/21 , 19 62 , that (I) (we) last saw the deceased alive on 1/21 , 19 62 , and that death occurred at 1/21 , 19 62 , M, from the causes and on the date stated above															
22a. SIGNATURE Charles Greenwell M.D.				22b. DATE SIGNED 1/22/62				22c. PHYSICIAN'S NAME (Type) Charles Greenwell M.D.				22d. ADDRESS Leonardtown, Maryland			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial				23b. DATE THEREOF 1/23/62				23c. NAME OF CEMETERY OR CREMATORY Warrenton				23d. LOCATION (City, town or county) (State) Warrenton, Virginia			
24. FUNERAL DIRECTOR'S SIGNATURE Sidduth-Moser				24a. REC'D BY REGISTRAR JAN 25 '62				24b. REGISTRAR'S SIGNATURE Arthur S. Evans				24c. ADDRESS Warrenton, Virginia			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain on the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Items 18-2 Film 306
2-5-62 ans

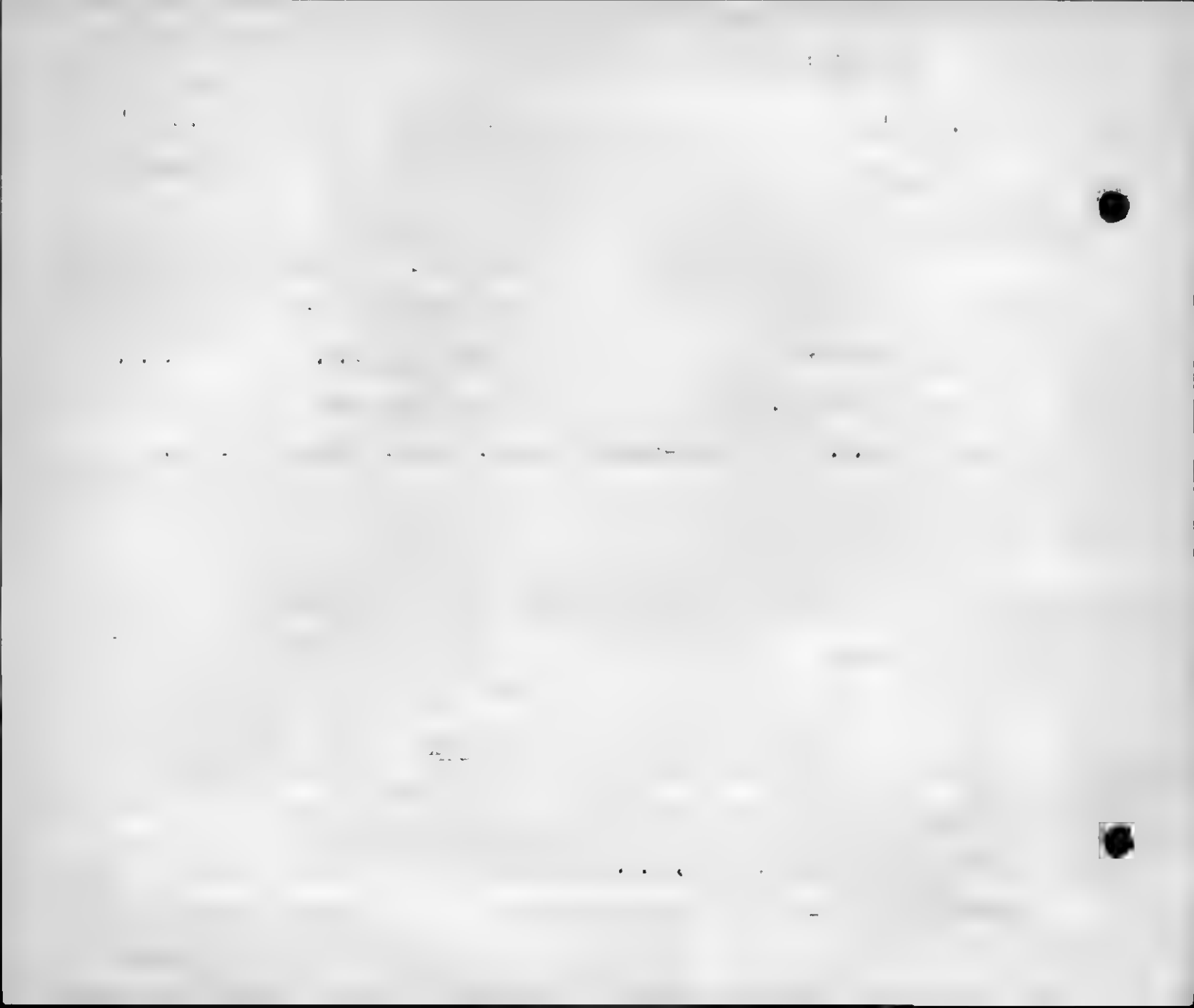
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01134 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01124

1. PLACE OF DEATH a. COUNTY St. Mary's				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland				b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Valley Lee				c. LENGTH OF STAY IN 1b Callaway				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Callaway			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Paul Anthony Jackson, Jr.				4. DATE OF DEATH Month January Day 17 Year 1962							
5. SEX Male				6. COLOR OR RACE white				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH February 20, 1922				9. AGE (In years last birthday) 39 yrs.				10. IF UNDER 1 YEAR Months 39 Days 39 Hours 39 Min. 39			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry Supervisor				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Washington D.C.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Paul Jackson Sr.				14. MOTHER'S MAIDEN NAME Lillian Hardy			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes W.W.2				16. SOCIAL SECURITY NO. 577-18-2698				17. INFORMANT Ethel M. Nelson, Leonardtown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Synergistic Poisoning with Alcohol and Doriden DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ingestion of Alcohol and Doriden				INTERVAL BETWEEN ONSET AND DEATH				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Ingestion of Alcohol and Doriden							
20c. TIME OF INJURY Month, Day, Year Hour X 8:50 p.m. 1/16 1962				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home			
20f. (City or town) Callaway				20g. (County) St. Marys				20h. (State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 1/18/62			
ACTUAL SIGNATURE Charles S. Petty				M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>							
EXAMINER'S NAME (Type) Charles S. Petty, M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				Address (Street, city, town, or county) Suitland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal				22b. DATE THEREOF 1-22-62				22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			
22d. LOCATION (City, town, or country) Suitland, Maryland				22e. (State) Md.							
23. FUNERAL DIRECTOR Wm J. Suckewald				ADDRESS Baltimore 17 Md				24a. REC'D BY REGISTRAR JAN 19 '62			
24b. REGISTRAR'S SIGNATURE Wm J. Suckewald				24c. (City, town, or county) Baltimore 17 Md				24d. (State) Md			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

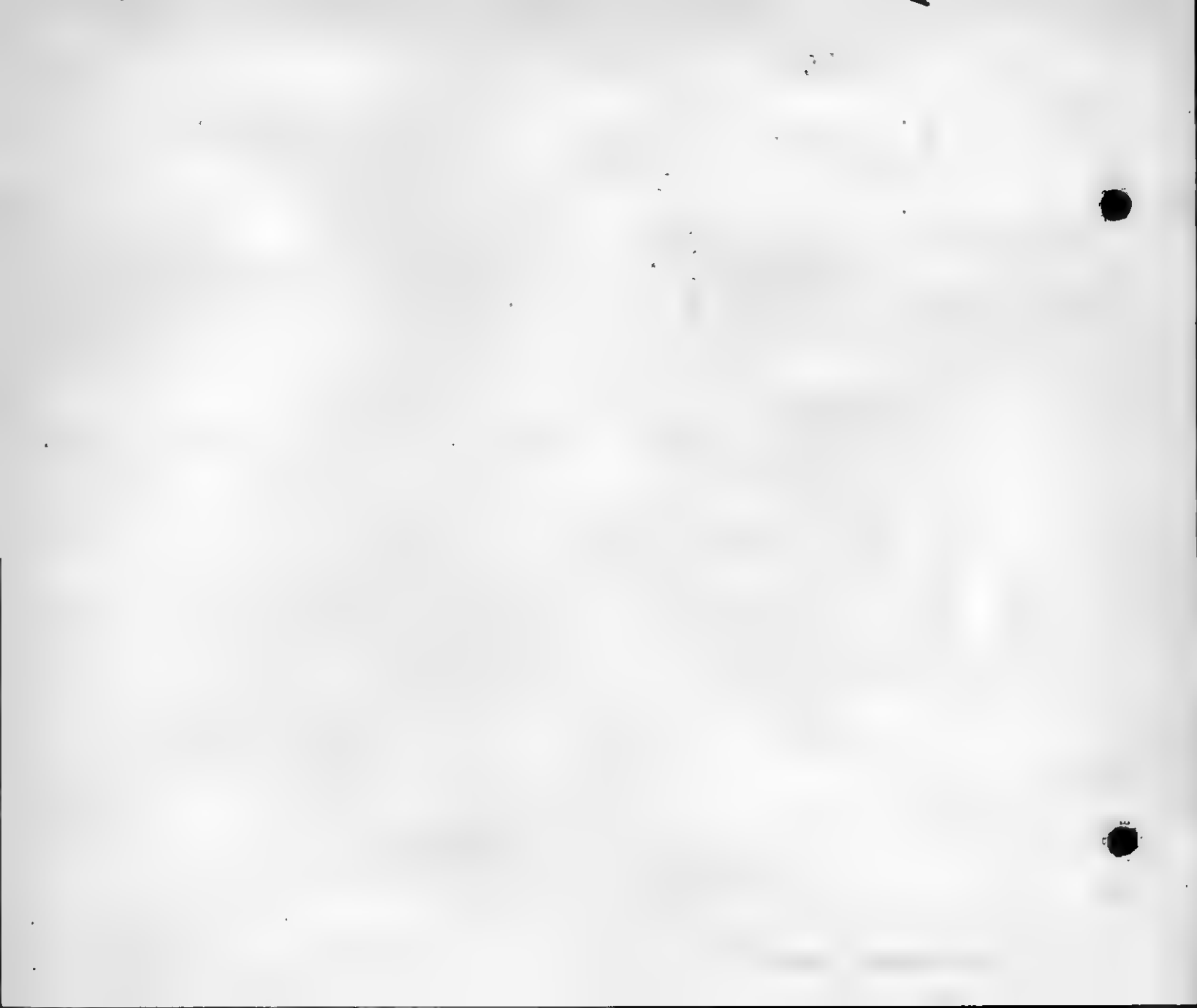
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01135

CERTIFICATE OF DEATH

01125

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtwn</u>		c. LENGTH OF STAY IN TB <u>1 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Mary's</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtwn</u>	
f. STREET ADDRESS <u>-----</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nettie</u> Middle <u>Belle</u> Last <u>Larrimore</u>		4. DATE OF DEATH Month <u>January</u> Day <u>25</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 21, 1888</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Robinson</u>		14. MOTHER'S MAIDEN NAME <u>Lena Maske</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Curtis C. Larrimore, II, Leonardtown, Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac failure</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c), stating the underlying cause last, (c) <u> </u> DUE TO <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>1/20</u> , 19 <u>59</u> to <u>1/25</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>1/25</u> , 19 <u>62</u> , and that death occurred at <u>7:30</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Charles Greenwell</u> M.D.		22b. DATE SIGNED <u>1/26/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles Greenwell, M.D.</u>		22d. ADDRESS <u>Leonardtwn, Maryland</u>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <u>Burial</u> <u>1/29/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>	
23d. LOCATION (City, town or county) (State) <u>Easton, Maryland</u>		23e. REC'D BY REGISTRAR <u> </u> 23f. REGISTRAR'S SIGNATURE <u> </u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Franklin Carroll</u>		24b. ADDRESS <u>Easton, Md.</u>	
25a. REC'D BY REGISTRAR <u> </u>		25b. REGISTRAR'S SIGNATURE <u> </u>	



may be reviewed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

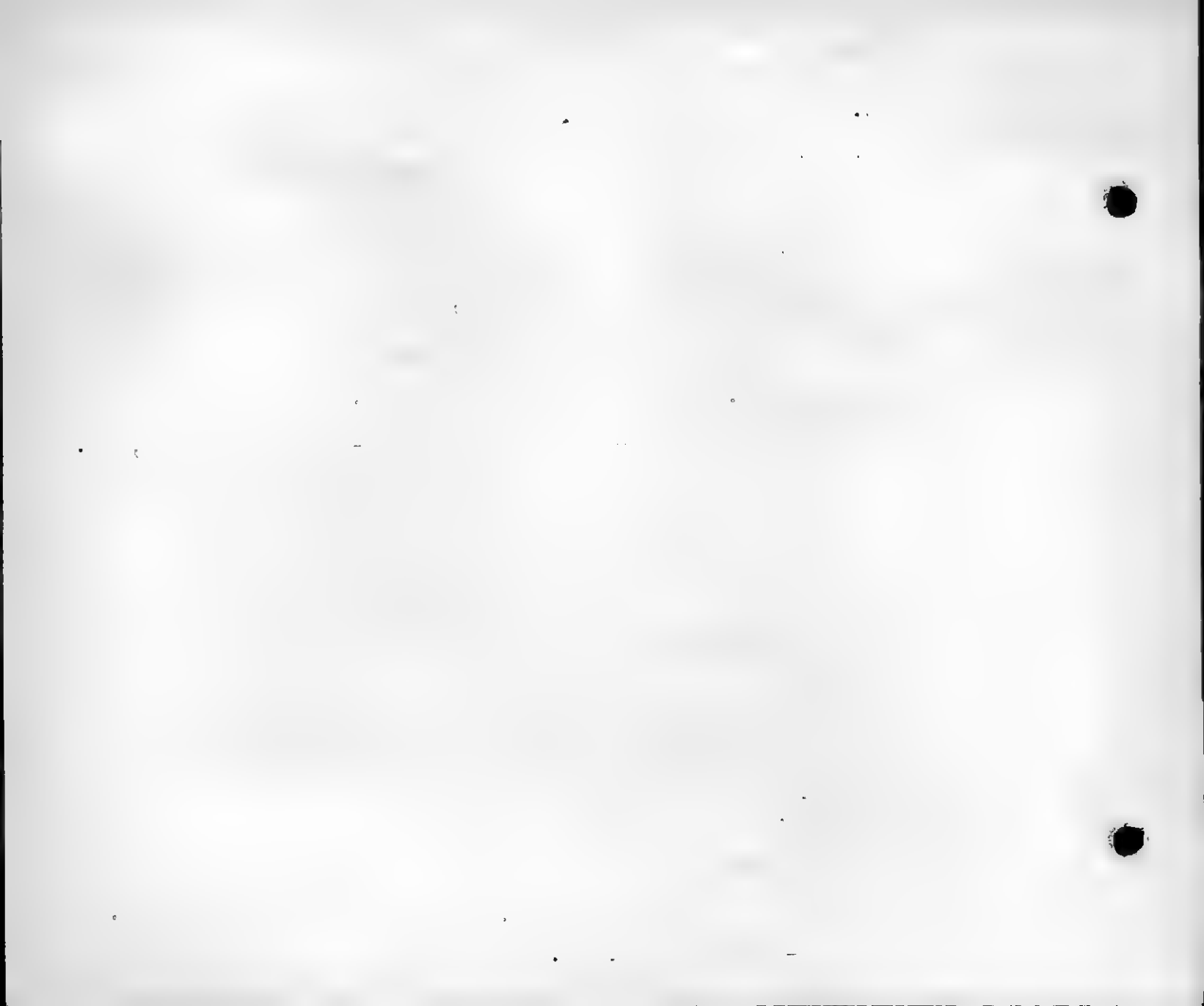
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MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MAYLAND
CERTIFICATE OF DEATH

01136

01126

1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mechanicsville				c. LENGTH OF STAY IN 1b X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First REVOUNE Middle D. Last LYLES				4. DATE OF DEATH Month January Day 15 Year 1962			
5. SEX female		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>		8. DATE OF BIRTH May 10, 1961	
9. AGE (in years last birthday) 8 yrs		10. IF UNDER 1 YEAR Months 8 Days 5		11. IF UNDER 24 HRS Hours 5 Min 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Thomas N. Young				14. MOTHER'S MAIDEN NAME Mary L. Lyles			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. ---		17. INFORMANT Mary L. Lyles - Charlotte Hall, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 593X IMMEDIATE CAUSE (a) Glomerular nephritis DUE TO (b) --- DUE TO (c) --- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 1 wk
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Preceded by measles							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. ---		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/13 1962 to 1/15 1962 , that (II) (we) last saw the deceased alive on 1/13 1962 , and that death occurred at 12:45 PM , from the causes and on the date stated above.							
22a. SIGNATURE J. Roy Guyther				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/15/62	
22c. PHYSICIAN'S NAME (Type) J. Roy Guyther, MD				22d. ADDRESS Mechanicsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/16/62		23c. NAME OF CEMETERY OR CREMATORY Ebenezer Cem.		23d. LOCATION (City, town, or county) (State) Charlotte Hall, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.				25a. REC'D BY REGISTRAR JAN 18 1962		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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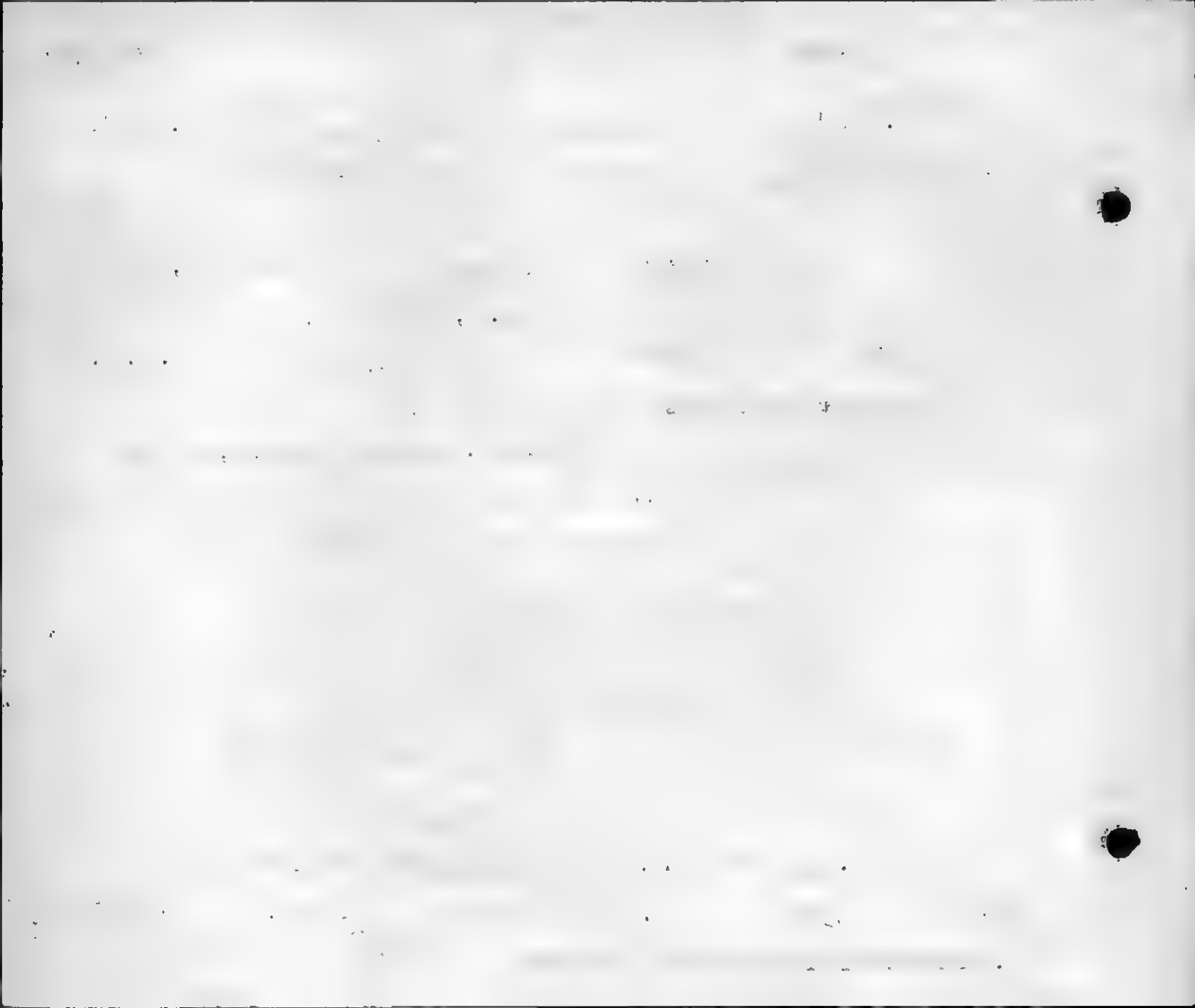


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Oraville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Oraville</u>	
c. LENGTH OF STAY IN 1b <u>20 years</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospita., give street address)			
3. NAME OF DECEASED (Type or print) <u>Ada Virginia Mattingly</u>		4. DATE OF DEATH <u>January 31, 1962</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 8, 1874</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
13. FATHER'S NAME <u>William Sylvester Adams</u>		14. MOTHER'S MAIDEN NAME <u>Alice ? ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>George G. Mattingly Oraville, Maryland</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> <u>Arteriosclerotic C.V. dis.</u> (b) <u>432</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>General thrombosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 30, 1948</u> to <u>Jan 31, 1962</u> that (I) (we) last saw the deceased alive on <u>Jan 30, 1962</u> and that death occurred at <u> </u> M. <u> </u> from the causes and on the date stated above.			
22a. SIGNATURE <u>J. Roy Guyther</u>		22b. DATE SIGNED <u>Jan 31, 1962</u>	
22c. PHYSICIAN'S NAME (Type or print) <u>J. Roy Guyther M.D.</u>		22d. ADDRESS <u>Mechanicsville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/5/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Morganza, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley Leonardtown, Maryland</u>		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>DATE 7 7 '62</u> <u> </u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

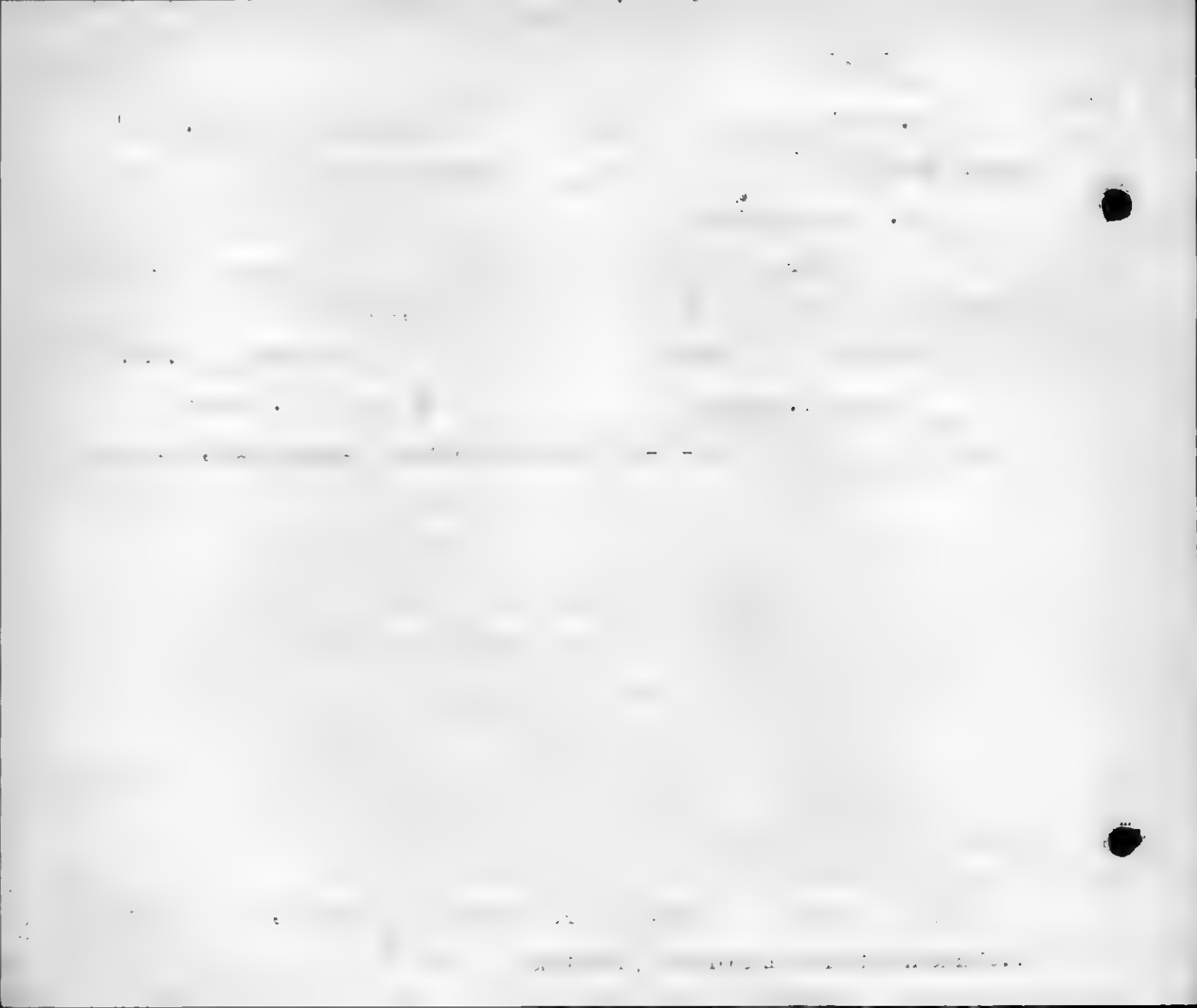
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01138

CERTIFICATE OF DEATH

01127

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtwn</u>		c. LENGTH OF STAY IN <u>7 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Mary's Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Oakley</u>	
f. STREET ADDRESS <u>St. Mary's Hospital</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary Bertha Parker</u>		4. DATE OF DEATH <u>January 1, 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 14, 1910</u>
9. AGE (In years last birthday) <u>51 yrs.</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas I. Fenwick</u>		14. MOTHER'S MAIDEN NAME <u>Charity A. Thomas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-34-4070</u>	
17. INFORMANT <u>Mrs Jenie Jones</u>		Address <u>Colton Point, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (b) <u>Cancer of uterus (cervix) with metastases</u> (c), stating the underlying cause last. <u>Gastric hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 mo 1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u>Gastric hemorrhage</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>am</u> <u>pm</u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1, 1961</u> to <u>Jan 1, 1962</u> that (I) (we) last saw the deceased alive on <u>Jan 1, 1962</u> and that death occurred at <u>11:00 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>W. Clarke Mattingley</u>		22b. DATE SIGNED <u>JAN 8 '62</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. Clarke Mattingley</u>		22d. ADDRESS <u>Leonardtwn, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/4/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Secred Heart Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Bushwood, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley</u>		25a. REC'D BY REGISTRAR <u>JAN 8 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>W. Clarke Mattingley</u>		25c. DATE <u>JAN 8 '62</u>	



01139

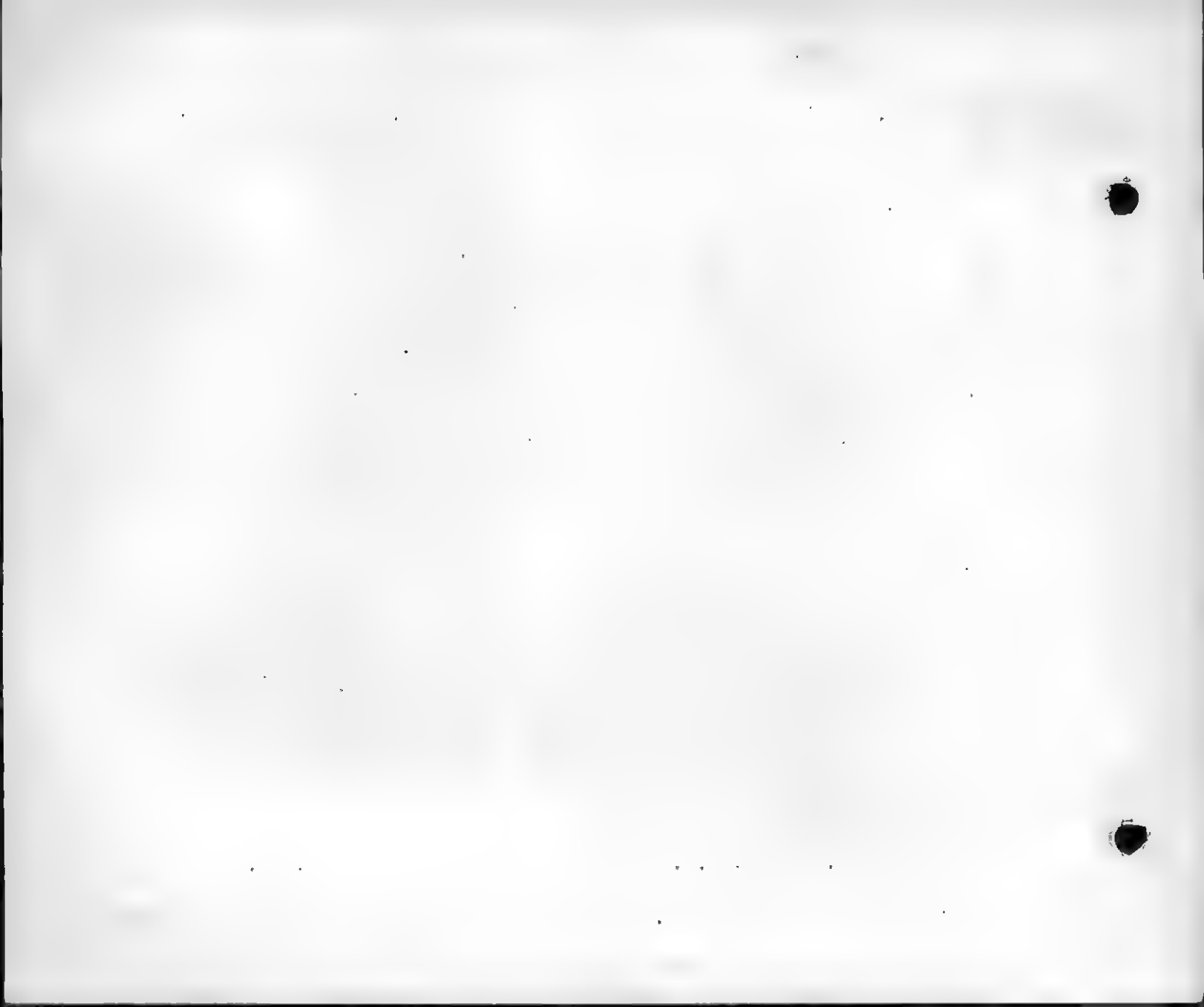
CERTIFICATE OF DEATH

Reg. Dist. No. 02337

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>St. Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>		c. LENGTH OF STAY IN lb <u>11 hours</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Mary's Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Wathen</u>		4. DATE OF DEATH Month Day Year <u>1-18-62</u> <u>19</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-18-62</u>
9. AGE (In years last birthday) yrs. <u>11</u>		10. IF UNDER 1 YEAR Months Days <u>11</u> <u>24</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Joseph Mattingly Wathen</u>		14. MOTHER'S MAIDEN NAME <u>Shirley Ann Hamilton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mother</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/17/62</u> 19 <u>62</u> to <u>1/18/62</u> , that I last saw the deceased alive on <u>1/17</u> 19 <u>62</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leon W. Berube</u> M.D.		DATE SIGNED <u>1/26/62</u>	
PHYSICIAN'S NAME (Type) <u>Leon W. Berube, M.D.</u>		<u>Mechanicsville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/20/62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Josephs</u>	22d. LOCATION (City, town, or county) (State) <u>Morganza, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Family</u>		ADDRESS <u>Same as # 2</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 7 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed in by the funeral director. The law also requires that the death certificate be signed by the attending physician and completed in by the funeral director. The law also requires that the death certificate be signed by the attending physician and completed in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01140

01128

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Park Hall c. LENGTH OF STAY IN 1b 3 months d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Home of Julia D. Courtney				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Medley's Neck d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Helen Cora Wilson		4. DATE OF DEATH Month January Day 14 Year 19 62		5. SEX Female Colored WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH July 4, 1877			
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 14 Days 19		IF UNDER 24 HRS. Hours 62 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Alexander Barnes		14. MOTHER'S MAIDEN NAME Sarah Swales			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Agnes A. Newton, 1322 Mass. Ave., S/E, Wash. D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure (chronic myocarditis) DUE TO (b) suphents - Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from 1/5/59 to 1/14/62, that (I) (we) last saw the deceased alive on 1/12/62, and that death occurred at 5A.M. from the causes and on the date stated above.							
22a. SIGNATURE Charles Greenwell M.D.		22b. DATE SIGNED 1/18/62		22c. PHYSICIAN'S NAME (Type) Charles Greenwell M.D.			
22d. ADDRESS Leonardtown, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					
23b. DATE THEREOF 1/18/'62		23c. NAME OF CEMETERY OR CREMATORY Our Lady's Chapel		23d. LOCATION (City, town or county) Medley's Neck			
23e. REC'D BY REGISTRAR JAN 24 '62		23f. REGISTRAR'S SIGNATURE W. Clarke Mattingley					
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley, Leonardtown, Maryland							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY St. Mary's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn c. LENGTH OF STAY IN 1b 15 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Mary's Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Leonardtown d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harry Milton Wood		4. DATE OF DEATH Month January Day 14 Year 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18, 1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 73 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Wood		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 579-09-5627	
17. INFORMANT Mabel O. Wood		Address Leonardtwn, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion DUE TO (b) Previous coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 5 hrs 2 wks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May , 19 61 , to Jan , 19 62 that (I) (we) last saw the deceased alive on 14 Jan 1962 , and that death occurred at 11:17 M, from the causes and on the date stated above.			
22a. SIGNATURE Leon B. Berbue		22b. DATE SIGNED 1/17/62	
22c. PHYSICIAN'S NAME (Type) Leon B. Berbue M. D.		22d. ADDRESS Mechanicsville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/18/62	23c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery	23d. LOCATION (City, town or county) (State) Great Mills, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		24. ADDRESS Leonardtwn, Maryland	
25a. REC'D BY REGISTRAR JAN 24 '62		25b. REGISTRAR'S SIGNATURE James L. Kenna	



01141

St. Mary's

CHATELAIN & CO. LTD.

St. Mary's

St. Mary's

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Hotel

St. Mary's

St. Mary's Hospital

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